February 14, 2003

SENATE BILL No. 462

DIGEST OF SB 462 (Updated February 12, 2003 1:30 PM - DI 104)

Citations Affected: IC 2-5; IC 27-8; noncode.

Synopsis: ICHIA revisions. Amends the comprehensive health insurance association (ICHIA) law concerning eligibility, preexisting conditions, prescription drug coverage, out of pocket expenses, chronic disease coverage, and premiums. Makes conforming and technical amendments.

Effective: July 1, 2003.

Miller, Lawson C, Simpson, Dillon

January 21, 2003, read first time and referred to Committee on Health and Provider Services.
February 13, 2003, amended, reported favorably — Do Pass.

February 14, 2003

First Regular Session 113th General Assembly (2003)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2002 Regular or Special Session of the General Assembly.

SENATE BILL No. 462

A BILL FOR AN ACT to amend the Indiana Code concerning insurance.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 2-5-23-8 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 8. Beginning May 1, 1997, the health policy advisory committee is established. At the request of the chairman, the health policy advisory committee shall provide information and otherwise assist the commission to perform the duties of the commission under this chapter. The health policy advisory committee members are ex officio and may not vote. The health policy advisory committee members shall be appointed from the general public and must include one (1) individual who represents each of the following:

(1) The interests of public hospitals.

(2) The interests of community mental health centers.

(3) The interests of community health centers.

(4) The interests of the long term care industry.

(5) The interests of health care professionals licensed under IC 25, but not licensed under IC 25-22.5.

(6) The interests of rural hospitals. An individual appointed under

this subdivision must be licensed under IC 25-22.5.

(7) The interests of health maintenance organizations (as defined in IC 27-13-1-19).

(8) The interests of for-profit health care facilities (as defined in ~~IC 27-8-10-1(l)).~~ **IC 27-8-10-1).**

(9) A statewide consumer organization.

(10) A statewide senior citizen organization.

(11) A statewide organization representing people with disabilities.

(12) Organized labor.

(13) The interests of businesses that purchase health insurance policies.

(14) The interests of businesses that provide employee welfare benefit plans (as defined in 29 U.S.C. 1002) that are self-funded.

(15) A minority community.

(16) The uninsured. An individual appointed under this subdivision must be and must have been chronically uninsured.

(17) An individual who is not associated with any organization, business, or profession represented in this subsection other than as a consumer.

SECTION 2. IC 27-8-10-1, AS AMENDED BY P.L.1-2001, SECTION 33, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 1. (a) The definitions in this section apply throughout this chapter.

(b) "Association" means the Indiana comprehensive health insurance association established under section 2.1 of this chapter.

(c) "Association policy" means a policy issued by the association that provides coverage specified in section 3 of this chapter. The term does not include a Medicare supplement policy that is issued under section 9 of this chapter.

(d) "Carrier" means an insurer providing medical, hospital, or surgical expense incurred health insurance policies.

(e) "Church plan" means a plan defined in the federal Employee Retirement Income Security Act of 1974 under 26 U.S.C. 414(e).

(f) "Commissioner" refers to the insurance commissioner.

(g) "Creditable coverage" has the meaning set forth in the federal Health Insurance Portability and Accountability Act of 1996 (26 U.S.C. 9801(c)(1)).

(h) "Eligible expenses" means those charges for health care services and articles provided for in section 3 of this chapter.

(i) "Federally eligible individual" means an individual:

(1) for whom, as of the date on which the individual seeks

coverage under this chapter, the aggregate period of creditable coverage is at least eighteen (18) months and whose most recent prior creditable coverage was under a:

(A) group health plan;

(B) governmental plan; or

(C) church plan;

or health insurance coverage in connection with any of these plans;

(2) who is not eligible for coverage under:

(A) a group health plan;

(B) Part A or Part B of Title XVIII of the federal Social Security Act; or

(C) a state plan under Title XIX of the federal Social Security Act (or any successor program);

and does not have other health insurance coverage;

(3) with respect to whom the individual's most recent coverage was not terminated for factors relating to nonpayment of premiums or fraud;

(4) who, if after being offered the option of continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (29 U.S.C. 1191b(d)(1)), or under a similar state program, elected such coverage; and

(5) who, if after electing continuation coverage described in subdivision (4), has exhausted continuation coverage under the provision or program.

(j) "Governmental plan" means a plan as defined under the federal Employee Retirement Income Security Act of 1974 (26 U.S.C. 414(d)) and any plan established or maintained for its employees by the United States government or by any agency or instrumentality of the United States government.

(k) "Group health plan" means an employee welfare benefit plan (as defined in 29 U.S.C. 1167(1)) to the extent that the plan provides medical care payments to, or on behalf of, employees or their dependents, as defined under the terms of the plan, directly or through insurance, reimbursement, or otherwise.

(l) "Health care facility" means any institution providing health care services that is licensed in this state, including institutions engaged principally in providing services for health maintenance organizations or for the diagnosis or treatment of human disease, pain, injury, deformity, or physical condition, including a general hospital, special hospital, mental hospital, public health center, diagnostic center, treatment center, rehabilitation center, extended care facility, skilled

nursing home, nursing home, intermediate care facility, tuberculosis hospital, chronic disease hospital, maternity hospital, outpatient clinic, home health care agency, bioanalytical laboratory, or central services facility servicing one (1) or more such institutions.

(m) "Health care institutions" means skilled nursing facilities, home health agencies, and hospitals.

(n) "Health care provider" means any physician, hospital, pharmacist, or other person who is licensed in Indiana to furnish health care services.

(o) "Health care services" means any services or products included in the furnishing to any individual of medical care, dental care, or hospitalization, or incident to the furnishing of such care or hospitalization, as well as the furnishing to any person of any other services or products for the purpose of preventing, alleviating, curing, or healing human illness or injury.

(p) "Health insurance" means hospital, surgical, and medical expense incurred policies, nonprofit service plan contracts, health maintenance organizations, limited service health maintenance organizations, and self-insured plans. However, the term "health insurance" does not include short term travel accident policies, accident only policies, fixed indemnity policies, automobile medical payment, or incidental coverage issued with or as a supplement to liability insurance.

(q) "Insured" means all individuals who are provided qualified comprehensive health insurance coverage under an individual policy, including all dependents and other insured persons, if any.

(r) "Medicaid" means medical assistance provided by the state under the Medicaid program under IC 12-15.

(s) "Medical care payment" means amounts paid for:

(1) the diagnosis, care, mitigation, treatment, or prevention of disease or amounts paid for the purpose of affecting any structure or function of the body;

(2) transportation primarily for and essential to Medicare services referred to in subdivision (1); and

(3) insurance covering medical care referred to in subdivisions (1) and (2).

(t) "Medically necessary" means health care services that the association has determined:

(1) are recommended by a legally qualified physician;

(2) are commonly and customarily recognized throughout the physician's profession as appropriate in the treatment of the patient's diagnosed illness; and

(3) are not primarily for the scholastic education or vocational training of the provider or patient.

(u) "Medicare" means Title XVIII of the federal Social Security Act (42 U.S.C. 1395 et seq.).

(v) "Policy" means a contract, policy, or plan of health insurance.

(w) "Policy year" means a twelve (12) month period during which a policy provides coverage or obligates the carrier to provide health care services.

(x) "Health maintenance organization" has the meaning set out in IC 27-13-1-19.

(y) **"Resident" means an individual who is:**

(1) legally domiciled in Indiana for at least one hundred eighty (180) days before applying for an association policy; or

(2) a federally eligible individual and legally domiciled in Indiana.

(z) "Self-insurer" means an employer who provides services, payment for, or reimbursement of any part of the cost of health care services other than payment of insurance premiums or subscriber charges to a carrier. However, the term "self-insurer" does not include an employer who is exempt from state insurance regulation by federal law, or an employer who is a political subdivision of the state of Indiana.

~~(z)~~ **(aa)** "Services of a skilled nursing facility" means services that must commence within fourteen (14) days following a confinement of at least three (3) consecutive days in a hospital for the same condition.

~~(aa)~~ **(bb)** "Skilled nursing facility", "home health agency", "hospital", and "home health services" have the meanings assigned to them in 42 U.S.C. 1395x.

~~(bb)~~ **(cc)** "Medicare supplement policy" means an individual policy of accident and sickness insurance that is designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, and surgical expenses of individuals who are eligible for Medicare benefits.

~~(cc)~~ **(dd)** "Limited service health maintenance organization" has the meaning set forth in IC 27-13-34-4.

SECTION 3. IC 27-8-10-2.1, AS AMENDED BY P.L.192-2002(ss), SECTION 169, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 2.1. (a) There is established a nonprofit legal entity to be referred to as the Indiana comprehensive health insurance association, which must assure that health insurance is made available throughout the year to each eligible Indiana resident applying to the association for coverage. All carriers, health

maintenance organizations, limited service health maintenance organizations, and self-insurers providing health insurance or health care services in Indiana must be members of the association. The association shall operate under a plan of operation established and approved under subsection (c) and shall exercise its powers through a board of directors established under this section.

(b) The board of directors of the association consists of seven (7) members whose principal residence is in Indiana selected as follows:

(1) Three (3) members to be appointed by the commissioner from the members of the association, one (1) of which must be a representative of a health maintenance organization.

(2) Two (2) members to be appointed by the commissioner shall be consumers representing policyholders.

(3) Two (2) members shall be the state budget director or designee and the commissioner of the department of insurance or designee.

The commissioner shall appoint the chairman of the board, and the board shall elect a secretary from its membership. The term of office of each appointed member is three (3) years, subject to eligibility for reappointment. Members of the board who are not state employees may be reimbursed from the association's funds for expenses incurred in attending meetings. The board shall meet at least semiannually, with the first meeting to be held not later than May 15 of each year.

(c) The association shall submit to the commissioner a plan of operation for the association and any amendments to the plan necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation becomes effective upon approval in writing by the commissioner consistent with the date on which the coverage under this chapter must be made available. The commissioner shall, after notice and hearing, approve the plan of operation if the plan is determined to be suitable to assure the fair, reasonable, and equitable administration of the association and provides for the sharing of association losses on an equitable, proportionate basis among the member carriers, health maintenance organizations, limited service health maintenance organizations, and self-insurers. If the association fails to submit a suitable plan of operation within one hundred eighty (180) days after the appointment of the board of directors, or at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall adopt rules under IC 4-22-2 necessary or advisable to implement this section. These rules are effective until modified by the commissioner or superseded by a plan submitted by the association and approved by

the commissioner. The plan of operation must:

(1) establish procedures for the handling and accounting of assets and money of the association;

(2) establish the amount and method of reimbursing members of the board;

(3) establish regular times and places for meetings of the board of directors;

(4) establish procedures for records to be kept of all financial transactions, and for the annual fiscal reporting to the commissioner;

(5) establish procedures whereby selections for the board of directors will be made and submitted to the commissioner for approval;

(6) contain additional provisions necessary or proper for the execution of the powers and duties of the association; and

(7) establish procedures for the periodic advertising of the general availability of the health insurance coverages from the association.

(d) The plan of operation may provide that any of the powers and duties of the association be delegated to a person who will perform functions similar to those of this association. A delegation under this section takes effect only with the approval of both the board of directors and the commissioner. The commissioner may not approve a delegation unless the protections afforded to the insured are substantially equivalent to or greater than those provided under this chapter.

(e) The association has the general powers and authority enumerated by this subsection in accordance with the plan of operation approved by the commissioner under subsection (c). The association has the general powers and authority granted under the laws of Indiana to carriers licensed to transact the kinds of health care services or health insurance described in section 1 of this chapter and also has the specific authority to do the following:

(1) Enter into contracts as are necessary or proper to carry out this chapter, subject to the approval of the commissioner.

(2) Sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against participating carriers.

(3) Take legal action necessary to avoid the payment of improper claims against the association or the coverage provided by or through the association.

(4) Establish a medical review committee to determine the

reasonably appropriate level and extent of health care services in each instance.

(5) Establish appropriate rates, scales of rates, rate classifications and rating adjustments, such rates not to be unreasonable in relation to the coverage provided and the reasonable operational expenses of the association.

(6) Pool risks among members.

(7) Issue policies of insurance on an indemnity or provision of service basis providing the coverage required by this chapter.

(8) Administer separate pools, separate accounts, or other plans or arrangements considered appropriate for separate members or groups of members.

(9) Operate and administer any combination of plans, pools, or other mechanisms considered appropriate to best accomplish the fair and equitable operation of the association.

(10) Appoint from among members appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the association, policy and other contract design, and any other function within the authority of the association.

(11) Hire an independent consultant.

(12) Develop a method of advising applicants of the availability of other coverages outside the association. ~~and may promulgate a list of health conditions the existence of which would deem an applicant eligible without demonstrating a rejection of coverage by one (1) carrier.~~

(13) Provide for the use of managed care plans for insureds, including the use of:

(A) health maintenance organizations; and

(B) preferred provider plans.

(14) Solicit bids directly from providers for coverage under this chapter.

(f) Rates for coverages issued by the association may not be unreasonable in relation to the benefits provided, the risk experience, and the reasonable expenses of providing the coverage. Separate scales of premium rates based on age apply for individual risks. Premium rates must take into consideration the extra morbidity and administration expenses, if any, for risks insured in the association. The rates for a given classification may not be more than ~~one~~ **two** hundred ~~fifty~~ percent ~~(150%)~~ **(200%)** of the average premium rate for that class charged by the five (5) carriers with the largest premium volume in the state during the preceding calendar year. In determining the average

rate of the five (5) largest carriers, the rates charged by the carriers shall be actuarially adjusted to determine the rate that would have been charged for benefits identical to those issued by the association. All rates adopted by the association must be submitted to the commissioner for approval.

(g) Following the close of the association's fiscal year, the association shall determine the net premiums, the expenses of administration, and the incurred losses for the year. Any net loss shall be assessed by the association to all members in proportion to their respective shares of total health insurance premiums, excluding premiums for Medicaid contracts with the state of Indiana, received in Indiana during the calendar year (or with paid losses in the year) coinciding with or ending during the fiscal year of the association. or any other equitable basis as may be provided in the plan of operation. For self-insurers, health maintenance organizations, and limited service health maintenance organizations that are members of the association, the proportionate share of losses must be determined through the application of an equitable formula based upon claims paid, excluding claims for Medicaid contracts with the state of Indiana, or the value of services provided. In sharing losses, the association may abate or defer in any part the assessment of a member, if, in the opinion of the board, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. The association may also provide for interim assessments against members of the association if necessary to assure the financial capability of the association to meet the incurred or estimated claims expenses or operating expenses of the association until the association's next fiscal year is completed. Net gains, if any, must be held at interest to offset future losses or allocated to reduce future premiums. Assessments must be determined by the board members specified in subsection (b)(1), subject to final approval by the commissioner.

(h) The association shall conduct periodic audits to assure the general accuracy of the financial data submitted to the association, and the association shall have an annual audit of its operations by an independent certified public accountant.

(i) The association is subject to examination by the department of insurance under IC 27-1-3.1. The board of directors shall submit, not later than March 30 of each year, a financial report for the preceding calendar year in a form approved by the commissioner.

(j) All policy forms issued by the association must conform in substance to prototype forms developed by the association, must in all other respects conform to the requirements of this chapter, and must be

filed with and approved by the commissioner before their use.

(k) The association may not issue an association policy to any individual who, on the effective date of the coverage applied for, does not meet the eligibility requirements of section 5.1 of this chapter.

~~(l) The association shall pay an agent's referral fee of twenty-five dollars ($25) to each insurance agent who refers an applicant to the association if that applicant is accepted.~~

~~(m)~~ **(l)** The association and the premium collected by the association shall be exempt from the premium tax, the adjusted gross income tax, or any combination of these upon revenues or income that may be imposed by the state.

~~(n)~~ **(m)** Members who after July 1, 1983, during any calendar year, have paid one (1) or more assessments levied under this chapter may either:

(1) take a credit against premium taxes, adjusted gross income taxes, or any combination of these, or similar taxes upon revenues or income of member insurers that may be imposed by the state, up to the amount of the taxes due for each calendar year in which the assessments were paid and for succeeding years until the aggregate of those assessments have been offset by either credits against those taxes or refunds from the association; or

(2) any member insurer may include in the rates for premiums charged for insurance policies to which this chapter applies amounts sufficient to recoup a sum equal to the amounts paid to the association by the member less any amounts returned to the member insurer by the association, and the rates shall not be deemed excessive by virtue of including an amount reasonably calculated to recoup assessments paid by the member.

~~(o)~~ **(n)** The association shall provide for the option of monthly collection of premiums.

SECTION 4. IC 27-8-10-2.3, AS ADDED BY P.L.167-2002, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 2.3. A member shall, not later than October 31 of each year, certify an independently audited report to the:

(1) association;

(2) legislative council; and

(3) department of insurance;

of the amount of tax credits taken against assessments by the member under section ~~2.1(n)(1)~~ **2.1(m)(1)** of this chapter during the previous calendar year.

SECTION 5. IC 27-8-10-3.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY

1, 2003]: **Sec. 3.5. (a) The association shall:**

(1) use the Medicaid preferred drug list developed under IC 12-15-35, except that a prescription drug prescribed for the treatment of human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), or hemophilia may not be placed on prior authorization; and

(2) implement a copayment structure;

for prescription drugs covered under an association policy.

(b) The copayment structure implemented under subsection (a) must be based on an annual actuarial analysis.

SECTION 6. IC 27-8-10-3.6 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: **Sec. 3.6. (a) The association shall:**

(1) establish a list of chronic diseases;

(2) approve disease management programs for management of chronic diseases; and

(3) approve:

(A) a mail order or Internet based pharmacy (as defined in IC 25-26-18-1); or

(B) a pharmacy that agrees to sell a prescription drug at the same price as an Internet based pharmacy;

through which an insured may obtain prescription drugs covered under an association policy for treatment of a chronic disease.

(b) If a disease management program is approved for a chronic disease under subsection (a), participation of an insured in the disease management program is required for coverage under an association policy of treatment of the insured's chronic disease.

(c) A prescription drug that is covered under an association policy for treatment of a chronic disease is covered:

(1) for the first sixty (60) days after the prescription drug is prescribed if the prescription drug is obtained from a:

(A) mail order or Internet based pharmacy approved under subsection (a); or

(B) pharmacy other than a mail order or Internet based pharmacy approved under subsection (a); and

(2) following the period specified in subdivision (1), only if the prescription drug is obtained from a mail order or Internet based pharmacy approved under subsection (a).

SECTION 7. IC 27-8-10-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 4. (a) Subject to the limitation provided in subsection (c), an association policy offered in

accordance with this chapter must impose a ~~five hundred dollar ($500)~~ deductible on a per person per policy year basis **in an amount:**

(1) equal to five hundred dollars ($500) for a policy year beginning in 2003; and

(2) that is determined for each policy year beginning after 2003 by an annual adjustment based on the percentage increase in the medical care component of the Consumer Price Index prepared by the United States Department of Labor.

The deductible must be applied to the ~~first five hundred dollars ($500) of~~ eligible expenses, **other than prescription drug expenses, first** incurred by the covered person **during the policy year.**

(b) Subject to the limitation provided in subsection (c), a mandatory coinsurance requirement shall be imposed at the rate of twenty percent (20%) of eligible expenses in excess of the mandatory deductible.

(c) The maximum aggregate out-of-pocket payments for eligible expenses, **other than prescription drug expenses,** by the insured in the form of deductibles and coinsurance may not exceed:

(1) one thousand five hundred dollars ($1,500) per individual or two thousand five hundred dollars ($2,500) per family, per policy year **for a policy year beginning in 2003; and**

(2) an amount that is determined for each policy year beginning after 2003 by an annual adjustment based on the percentage increase in the medical care component of the Consumer Price Index prepared by the United States Department of Labor.

SECTION 8. IC 27-8-10-5.1, AS AMENDED BY P.L.233-1999, SECTION 11, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 5.1. (a) Except as provided in subsections (b) and (c), a person is not eligible for an association policy if, at the effective date of coverage, the person has or is eligible for coverage under any insurance plan that equals or exceeds the minimum requirements for accident and sickness insurance policies issued in Indiana as set forth in IC 27. Coverage under any association policy is in excess of, and may not duplicate, coverage under any other form of health insurance.

(b) Except as provided in IC 27-13-16-4, a person is eligible for an association policy upon a showing that:

(1) the person has been rejected by one (1) carrier for coverage under any insurance plan that equals or exceeds the minimum requirements for accident and sickness insurance policies issued in Indiana, as set forth in IC 27, without material underwriting restrictions;

(2) an insurer has refused to issue insurance except at a rate exceeding the association plan rate; or

(3) the person is a federally eligible individual.

For the purposes of this subsection, eligibility for Medicare coverage does not disqualify a person who is less than sixty-five (65) years of age from eligibility for an association policy.

~~(c) The board of directors may establish procedures that would permit:~~

~~(1) an association policy to be issued to persons who are covered by a group insurance arrangement when that person or a dependent's health condition is such that the group's coverage is in jeopardy of termination or material rate increases because of that person's or dependent's medical claims experience; and~~

~~(2) an association policy to be issued without any limitation on preexisting conditions to a person who is covered by a health insurance arrangement when that person's coverage is scheduled to terminate for any reason beyond the person's control.~~

(c) Coverage under an association policy terminates as follows:

(1) On the date an insured is no longer a resident of Indiana.

(2) On the date an insured requests cancellation of the association policy.

(3) On the date of the death of an insured.

(4) At the end of the policy period for which the premium has been paid.

(5) On the date the insured no longer meets the eligibility requirements under this section.

(d) An association policy must provide that coverage of a dependent unmarried child terminates when the child becomes nineteen (19) years of age (or twenty-five (25) years of age if the child is enrolled full-time in an accredited educational institution). The policy must also provide in substance that attainment of the limiting age does not operate to terminate a dependent unmarried child's coverage while the dependent is and continues to be both:

(1) incapable of self-sustaining employment by reason of mental retardation or mental or physical disability; and

(2) chiefly dependent upon the person in whose name the contract is issued for support and maintenance.

However, proof of such incapacity and dependency must be furnished to the carrier within one hundred twenty (120) days of the child's attainment of the limiting age, and subsequently as may be required by the carrier, but not more frequently than annually after the two (2) year period following the child's attainment of the limiting age.

(e) An association policy that provides coverage for a family member of the person in whose name the contract is issued must, as to the family member's coverage, also provide that the health insurance benefits applicable for children are payable with respect to a newly born child of the person in whose name the contract is issued from the moment of birth. The coverage for newly born children must consist of coverage of injury or illness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium is required to provide coverage for the child, the contract may require that notification of the birth of a child and payment of the required premium must be furnished to the carrier within thirty-one (31) days after the date of birth in order to have the coverage continued beyond the thirty-one (31) day period.

(f) Except as provided in subsection (g), an association policy may contain provisions under which coverage is excluded during a period of ~~three (3)~~ **six (6)** months following the effective date of coverage as to a given covered individual for preexisting conditions, as long as medical advice or treatment was recommended or received within a period of ~~three (3)~~ **six (6)** months before the effective date of coverage. This subsection may not be construed to prohibit preexisting condition provisions in an insurance policy that are more favorable to the insured.

(g) If a person applies for an association policy within six (6) months after termination of the person's coverage under a health insurance arrangement and the person meets the eligibility requirements of subsection (b), then an association policy may not contain provisions under which:

(1) coverage as to a given individual is delayed to a date after the effective date or excluded from the policy; or

(2) coverage as to a given condition is denied;

on the basis of a preexisting health condition. This subsection may not be construed to prohibit preexisting condition provisions in an insurance policy that are more favorable to the insured.

(h) For purposes of this section, coverage under a health insurance arrangement includes, but is not limited to, coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985.

SECTION 9. IC 27-8-10-6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 6. (a) An association policy offered under this chapter must contain provisions under which the association is obligated to renew the contract until:

(1) the date that coverage terminates under section 5.1 of this chapter; or

(2) the day on which the individual in whose name the contract is

issued first becomes eligible for Medicare coverage, except that in a family policy covering both husband and wife, the age of the younger spouse must be used as the basis for meeting the durational requirement of this ~~subsection.~~ **subdivision.**

(b) The association may not change the rates for association policies or Medicare supplement policies except on a class basis with a clear disclosure in the policy of the association's right to do so.

(c) An association policy offered under this chapter must provide that upon the death of the individual in whose name the contract is issued, every other individual then covered under the contract may elect, within a period specified in the contract, to continue coverage under the same or a different contract until such time as he would have ceased to be entitled to coverage had the individual in whose name the contract was issued lived.

SECTION 10. IC 27-8-10-10 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 10. Before January 1, 1996, the board of directors of the association shall establish eligibility guidelines for the issuance of an association policy under this chapter to prohibit an:

(1) employer;

(2) insurance ~~agent;~~ **producer;** or

(3) insurance broker;

from placing in or referring to the association an individual who works for an employer who offers employees an employee welfare benefit plan (as defined in 29 U.S.C. 1002).

SECTION 11. [EFFECTIVE JULY 1, 2003] **IC 27-8-10-3.5 and IC 27-8-10-3.6, both as added by this act, and IC 27-8-10-4 and IC 27-8-10-5.1, both as amended by this act, apply to an association policy that is issued, delivered, amended, or renewed after June 30, 2003.**

SENATE MOTION

Mr. President: I move that Senator Lawson C be added as second author and Senators Simpson and Dillon be added as coauthors of Senate Bill 462.

MILLER

COMMITTEE REPORT

Mr. President: The Senate Committee on Health and Provider Services, to which was referred Senate Bill No. 462, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 11, line 3, delete "IC 12-15-35;" and insert "**IC 12-15-35, except that a prescription drug prescribed for the treatment of human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), or hemophilia may not be placed on prior authorization;**".

Page 11, line 11, delete "and".

Page 11, line 13, delete "." and insert "**; and**".

Page 11, between lines 13 and 14, begin a new line block indented and insert:

"**(3) approve:**

(A) a mail order or Internet based pharmacy (as defined in IC 25-26-18-1); or

(B) a pharmacy that agrees to sell a prescription drug at the same price as an Internet based pharmacy;

through which an insured may obtain prescription drugs covered under an association policy for treatment of a chronic disease.".

Page 11, between lines 17 and 18, begin a new paragraph and insert:

"**(c) A prescription drug that is covered under an association policy for treatment of a chronic disease is covered:**

(1) for the first sixty (60) days after the prescription drug is prescribed if the prescription drug is obtained from a:

(A) mail order or Internet based pharmacy approved under subsection (a); or

(B) pharmacy other than a mail order or Internet based pharmacy approved under subsection (a); and

(2) following the period specified in subdivision (1), only if the prescription drug is obtained from a mail order or Internet based pharmacy approved under subsection (a).".

and when so amended that said bill do pass.

(Reference is to SB 462 as introduced.)

MILLER, Chairperson

Committee Vote: Yeas 8, Nays 1.